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DETERRING PHYSICIAN UTILIZATION: MEDICAL CARE USER FEES IN CANADA

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Abstract

The costs of hospital and medical care in Canada are borne by the provincial medicare programs and a sizeable proportion of these costs are reimbursed through federal government transfer payments. Increasingly, user fees (a charge to the patient over and above the government payment made on behalf of patients) are being introduced by hospitals and physicians despite opposition from the federal government. In the province of Alberta, user fees charged by physicians take the form of an additional bill, a fee directly charged patients in a practice known as extra-billing. This survey shows that extra-billing is widely opposed by the general public and that the practice is perceived, especially by the poor, sick, and elderly, as a deterrent to needed care. User fees in the form of direct charges to the patient limit accessibility to medical services and therefore violate the principle of universal and equal access to care which is one of the guiding principles of the health care insurance program in Canada.

Deterring Physician Utilization: Medical Care User Fees in Canada

Universal hospital insurance was established in Canada in 1957 under the Hospital Insurance and Diagnostic Services Act. Insurance for medical care (to complement hospital insurance) was provided under the Medical Care Act of 1966. The 1966 act was guided by five principles: 1) universality - coverage of all Canadians, 2) accessibility - reasonable access to services, 3) comprehensiveness - a broad range of insured services, 4) portability - coverage could be carried from one province to another, and 5) public administration - the program was to be publicly administered without private sector involvement.

The two federal health insurance acts allowed the federal government to share the costs of provincial hospital and medical services and to dictate certain guidelines such as the five principles listed above. While health care in Canada is a provincial jurisdiction, all ten provinces and the two territories agreed to participate in the plans since the federal government was providing a significant percentage of the necessary funding. Public health insurance for hospital and medical services has been a reality for all Canadian residents since 1972 when the Yukon Territory joined the medicare program (1-3). Funding for this public insurance plan is derived at the federal level from general tax revenues. Provincial funding is based upon a combination of taxes, premiums, and user fees. Ontario, Alberta, British Columbia, and the Yukon currently collect premiums on a universal basis although all exempt the poor and all but British Columbia exempt the elderly (3).

User fees may be charged by hospitals and/or by physicians. User fees

are charged by hospitals in five of the ten provinces under various formulae. User fees charged by physicians come under various provincial guidelines. At the extreme is Quebec which requires a physician who wishes to directly bill a patient to opt out of medicare with the patient bearing the full cost of service. Less extreme are Newfoundland, Ontario, and Manitoba who reimburse patients (up to the level of the provincial fee schedule) for services obtained from opted-out physicians. British Columbia and the two territories also use this strategy although their physicians have not exercised the option. The remaining five provinces do not require a physician who wishes to levy direct charges on patients to opt out of medicare. Instead these provinces allow the physician to bill the province for the amount dictated by the fee schedule and in addition allow the physician to charge the patient a fee (3).

This procedure of charging the patient an additional fee is referred to as "balance billing" by the medical profession, the "balance" being the difference between what the province pays for a medical service and what the physician determines that service is worth. The practice is commonly termed "extra billing" by patients and the media since there is indeed an "extra" bill.

The question of whether these premiums and user fees violate the principle of accessibility has become a topic of debate. Those opposed to fees and/or premiums argue that the poor, the elderly, and the chronically ill who are likely to need medical care and who can least afford to pay, will be deterred from seeking necessary care (2-4). Before Medicare, for example, the poor were less likely to see a doctor though they were more likely to be sick (3,5). After Medicare the level of service obtained by

the poor rose (6-12). It is feared that the growing practice of extra-billing will reinstate a situation of unequal access (2-4).

Those in favour of user fees, however, argue that these fees make the health care delivery system more efficient by deterring unnecessary demands for care. It is also argued that user fees are a means of raising funds for an otherwise underfunded health care system (13-16). In addition, many physicians maintain that they have a professional right to charge what they think their services are worth. This final argument puts the medical profession in Canada in the unique position of having a monopoly with guaranteed fee for service (according to a schedule negotiated by the relevant provincial medical association and the provincial government) and also claiming a free-enterprise right to increase that fee through direct user charges.

The purpose of this research was to determine if user fees provide a positive deterrent, i.e. control unnecessary demand, or provide a negative deterrent by restricting access to necessary services for those social groups with limited ability to pay. This study was intended to complement the small body of Canadian research focusing on the effects of extra-billing (17-19).

The Hypotheses

Three hypotheses are addressed:

1. it is expected that the poor, elderly, and ill will be more likely to experience health problems and therefore more likely to visit the physician (3,20);
2. it is expected that the poor, elderly, and ill will be more opposed to

extra-billing, less satisfied with medical care, more likely to perceive a deterioration of health care quality, and more likely to report financial factors as a deterrent to seeking medical care (-18,19); and

3. further to hypothesis 2, it is hypothesized that the poor and ill and elderly person is in multiple jeopardy, i.e., there will be interaction effects among the age, socio-economic, and health status variables (21, 22).

The Survey

The survey was a part of the 1982 Edmonton Area Study which is an annual survey following a general 'quality of life' theme with an additional focus on special topics and issues. The sampling frame consisted of a computerized list of addresses compiled by the City of Edmonton from the 1981 civic census. A simple random sample of 667 addresses was selected for face-to-face interviewing. Within each household, one respondent 18 years of age or older was selected. Because adult males tend to be more difficult to contact, an interview with an adult male was requested initially and secondly an interview with an adult female. This strategy provided 507 completed interviews of which 47.3% were with male respondents and 52.7% with females. The interviewing was done during February and March of 1982. The sample was consistent with the 1976 Census of Canada for Edmonton on variables such as age and household size.

The following questions were asked regarding extra-billing:

1. How many visits altogether have you made to all your physicians in the last 12 months?

2. In the last 12 months how many different medical doctors have you visited in their offices?
3. How many of the doctors that you visited in the last 12 months charged you a fee in addition to the fee that Medicare paid the doctor?
4. How much do you agree or disagree with a doctor charging you a fee in addition to the fee that Medicare pays the doctor? (1=strongly disagree to 7=strongly agree)
5. To what extent do you think the standard of health care has suffered because of the fee and billing dispute between the Alberta Medical Association and the Provincial Government, a) as far as your personal health care was concerned? b) as far as health care for most Albertans was concerned? (not at all, very little, some, a great deal)
6. In what way (has the standard of health care suffered)? (unwilling/reluct-ant to visit -- owing to 1. cost, 2. quality of treatment, 3. quantity of treatment, or 4. hassle; 5. quality of care declined on visit; 6. quantity of care declined on visit; 7. other).
7. How satisfied or dissatisfied are you, generally speaking, with the standard of medical care provided by your physicians?
8. Additional questions determined gender, age, socio-economic status (family income), self-rated health status (poor, fair, good, excellent), and disability days (number of days cut down on things normally done because of health in the past year).

The Methods of Analysis

The analysis utilized cross-tabulation, bivariate linear regression, and analysis of variance (23). For the cross-tabulation and analysis of

variance procedures the independent variables were collapsed as follows: age (18-49, 50-64, 65+), family income ($0-9999, 10,000-19,999, 20,000-29,999, 30,000-39,999, 40,000+), health (poor/fair, good, excellent), and disability days (0, 1-14, 15+).

The Findings

Of the total sample, 85% visited at least one physician in the past year. Of those who visited one or more doctors, 37% were extra-billed at least once. While the trend in Alberta is towards an increased level of extra-billing, the phenomenon is by no means universal. Many doctors do not extra-bill and extra-billing doctors do not necessarily bill all of their patients.

The Alberta Medical Association encourages physicians not to extra-bill the elderly or those who cannot afford to pay. The survey data do show that the elderly (65 and older) are less likely to be extra-billed (X^2 = 10, 2df; p = .006). There were no significant differences among income groups or health status categories with respect to the practice of extra-billing.

The first hypothesis studied postulates that the ill, elderly, and poor will have more health problems and will be more likely to visit the physician. With respect to persons who are ill, the data show that the worse the self-reported health status, the more visits to the doctor and the more doctors visited (r's = -.30 and -.23; p < .01). Similarly, the more disability days, the more visits to the doctor and the more doctors visited (r's = .43 and .34;
p < .001). The elderly, with their increased risk of health problems, also made more visits to the doctor (X^2 = 24, 10df; p = .008) in comparison with

non-elderly respondents.

There was no evidence, however, that the poor made greater or lesser use of physician services. Given that the poor are more likely to have health problems ($r = .18$; $p < .001$), it is expected that the poor would visit the doctor more than the non-poor. One might tentatively assume, therefore, that extra-billing is deterring physician visits for the financially disadvantaged.

Hypothesis two addresses this assumption, i.e., that the poor and also the elderly and sick will be affected more adversely by extra-billing. The data show that for the general public, reaction to extra-billing is one of very strong opposition. Sixty-four percent of all respondents disagree with the practice and fully 44% of the sample strongly disagree (scale value 1 on a 7 point scale). Another 17% of the total sample are neutral leaving only 18% supportive of extra-billing.

For the elderly and the poor, Tables 1 and 2 show that these groups are more likely to disagree with extra-billing. Fully 73% of elderly respondents strongly disagree with the practice as compared to 44% of the total sample. With respect to the poor, of those with household incomes under $10,000, 78% were opposed to extra-billing in comparison to 55% of respondents with incomes over $40,000. There was no relationship between health status and (dis)agreement with extra-billing.

When asked to what extent health care had suffered as a result of the extra-billing issue, almost one-third of the respondents in the sample felt that their own health care had suffered. Of those who felt that their own health care had deteriorated, 40% cited unwillingness to seek care due to cost as the reason. No other single reason received comparable endorsement.

TABLE 1

Percentage Distribution of Responents Who Reported Agreement or Disagreement with a Doctor Charging a Fee in Addition to the Fee that Medicare Pays, by Age

Level of Agreement or Disagreement		Age[1] 18-49	50-64	65+	Total
Strongly disagree	1	41	43	73	44
	2	12	14	2	11
	3	11	6	7	9
	4	19	15	7	17
	5	10	13	7	10
Strongly agree[2]	6,7	8	10	7	8
Total[3]		101	101	98	99
(n)		(363)	(80)	(41)	(485)

1. Chi-Square = 20 with 10 df; p = .03

2. Response codes 6 and 7 were collapsed due to relatively small frequencies.

3. Totals are different from 100 due to rounding error.

TABLE 2

Percentage Distribution of Respondents Who Reported Agreement or Disagreement with a Doctor Charging a Fee in Addition to the Fee that Medicare Pays, by Household Income

Level of Agreement or Disagreement		Household Income of Respondent[1]				
		under $10,000	10,000-19,999	20,000-29,999	30,000-39,999	40,000+
Strongly disagree	1	46	49	43	46	35
	2	21	8	13	11	10
	3	11	10	10	6	10
	4	14	16	21	19	19
	5	4	14	8	11	13
Strongly agree	6,7	4	4	6	8	13
Total[2]		100	101	101	101	100
(n)		(44)	(80)	(106)	(85)	(122)

1. Chi-square = 21 with 20 df; p = .38. The linear correlation is r = .16, p = .001.

2. Differences from 100 are due to rounding error.

(Under Medicare the government pays the physician for services rendered and therefore "cost" to the patient refers to the extra-billing charge).

Table 3 shows that those who were actually extra-billed were more likely to perceive a deterioration in their medical services than those who did not experience extra-billing. Table 4 shows that this effect of extra-billing is especially pronounced among the poor, sick, and elderly. That is, while the experience of being extra-billed has little impact on the perceived quality of services for the non-poor, non-sick, and non-elderly, being extra-billed does contribute significantly for the poor, sick, and elderly to a perception of deteriorated health care services.

Most respondents (84%) felt that, in general, health care had suffered for Albertans as a whole. Of those who felt that the health care of Albertans had suffered, fully 70% cited unwillingness to seek care due to cost as the major reason. There was some indication that the poor and elderly were more likely to cite cost as a negative factor affecting physician utilization.

With regards to the degree of satisfaction or dissatisfaction with medical care, 39% were very satisfied (scale value 7 on a 7-point scale) and 86% were satisfied (scale values 5-7). The elderly, in comparison to the non-elderly, were more likely to be satisfied ($r = .21$; $p < .001$).

While females were more likely than males to visit the doctor ($X^2 = 26$, 2df; $p = .0001$), there were no gender differences in the evaluations of extra-billing, health care, and so on. Gender, therefore, was not used as a control variable.

Summarizing the results with respect to hypothesis two, it has been found that while satisfaction with medical care is very high, there is

TABLE 3

Perceived Deterioration in Own Health Care Services,

By Experience of Extra-Billing

Perceived Deterioration in Own Health Care Services	Extra-Billed in Past Year	
	No[1]	Yes
No	73.8	66.0
Yes	26.2	34.0
Total	100	100
(n)	(305)	(150)

1. Includes 62 respondents who did not visit a physician.

Corrected X^2 = 2.6, 1 df; p = .11

TABLE 4

Percentages of Respondents Perceiving Deterioration in Own Health Care Services, by Experience of Extra-Billing and Status

Status	Percentage Perceiving Deterioration in Own Health Care Services: Not Extra-Billed in Past Year	Extra-Billed in Past Year	Significance of Test for Difference Between Proportions[1]
Sick (poor, fair health)	27	60	<.01
Not sick (good, excellent health)	27	29	NS
Sick (15 + disability days)	22	44	.04
Not sick (< 15 disability days)	28	31	NS
Poor (< $20,000)	32	48	.06
Not poor (20,000+)	26	31	NS
Poor (< $10,000)	32	64	.04
Not poor (10,000+)	28	34	NS
Elderly (65+)	26	83	<.01
Not Elderly (< 65)	27	32	NS
All Respondents	26	34	.04

1. Probability values are for a one-tailed test. See (24) for the statistical formula.

strong opposition to extra-billing. The evidence suggests that extra-billing is perceived especially by the poor, sick, and elderly, as a threat to good and accessible health care.

Hypothesis three postulates that there will be interaction among the statuses of poor, elderly, and sick; that is, those who fall into all three of these categories should perceive themselves to be most deterred from seeking needed medical care when cost in the form of extra-billing is a barrier. Analysis of variance failed to provide support for this hypothesis. The findings discussed previously suggest that the public opposes extra-billing because it is feared that the practice will become a (more) significant deterrent to necessary medical care. Should extra-billing become more widespread and should the dollar amount of the billing become higher, statistical support for the multiple-jeopardy hypothesis would be more likely.

Summary and Discussion

Of all persons using physician services in Edmonton, Alberta in 1981, just over one-third experienced extra-billing (were charged a fee by the physician in addition to the fee paid by provincial medical insurance). While extra-billing is not currently universal in Alberta, the practice has increased in recent years.

Extra-billing for physician services and user fees in general are defended with two arguments: 1) the allegation that health care in Canada is currently underfunded and that user fees are necessary to raise revenues and/or protect the provider's right to set fees; and 2) the contention that user fees are needed to deter unnecessary demands for health care.

Legitimate requests for health care together with unnecessary usage of the health system constitute overall demand. User fees, especially when they are substantial, do deter overall demand, although it is not at all clear that they deter only the unnecessary component of that demand (13). This study shows that the public and especially the poor and the elderly are strongly opposed to user fees and perceive user fees as a deterrent to proper medical care. When the poor, sick, and elderly experience extra-billing they are more likely than the non-poor, non-sick, and non-elderly to perceive a deterioration in health care services. In this sense, user fees are discriminatory. Extra-billing, as employed in the Canadian context does "limit equitable access" to health care and therefore violates one of the guiding principles of Canadian health insurance.

The federal government and the public lean towards a position banning all user fees. This means that the costs of health care in Canada would come from general tax revenues. Given the progressive nature of Canada's tax system, it could be argued that this means of raising funds is also discriminatory in that the least advantaged pay nothing while the most advantaged pay more. This kind of discrimination - progressive taxation - has been widely accepted and is viewed as more acceptable than a regressive tax such as a user fee which is perceived by this study's respondents to act as a deterrent to necessary medical care.

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